

Cialis, Levitra, and Viagra Prior Authorization Request Form



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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none">The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477
	<ul style="list-style-type: none">The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at https://rxnet.army.mil/pec/forms_criteria.php. This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (Please Print)

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:	_____	Secure Fax #:	_____

Please indicate which medication is being prescribed: ☐ **Cialis** ☐ **Levitra** ☐ **Viagra**

Step 2 Please consider the following:

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

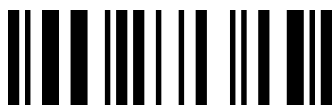
Step 3 1. Please indicate the patient's gender.

<input type="checkbox"/> Female	Please go to Section 1 for Female patients
<input type="checkbox"/> Male	Please go to Section 2 for Male patients on Page 2

Section 1 – Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Proceed to Question 2
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Coverage approved Please complete Question 4	<input type="checkbox"/> No Proceed to Question 3
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	<input type="checkbox"/> Yes Coverage approved Please complete Question 4	<input type="checkbox"/> No Coverage not approved
4. What is the dosing regimen?		

Please go to **Step 4** on Page 3.



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Section 2 – Male patients

1. Is the requested medication Levitra?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> No STOP. Go to Section 3 on Page 3
2. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to Question 3	<input type="checkbox"/> No Proceed to Question 6
3. Is the patient 40 years of age or older?	<input type="checkbox"/> Yes Do not submit form. Prior authorization is not required for males 40 years or older.	<input type="checkbox"/> No Proceed to Question 4
4. Is the PDE-5 inhibitor being prescribed for the treatment of erectile dysfunction of organic origin? Organic impotence is considered a consequence of chronic medical conditions that result in impaired arterial blood flow or nerve damage, mixed organic/psychogenic causes, and necessary use of causative medications that cannot be reduced or discontinued. TRICARE regulations specifically exclude coverage of therapies for erectile dysfunction that is not of organic origin.	<input type="checkbox"/> Yes Coverage approved	<input type="checkbox"/> No Proceed to Question 5
5. Is the indication for the preservation or restoration of erectile function following prostatectomy?	<input type="checkbox"/> Yes Coverage approved To determine quantity requirements, please complete Question 8	<input type="checkbox"/> No Proceed to Question 6
6. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Coverage approved To determine quantity requirements, please complete Question 8	<input type="checkbox"/> No Proceed to Question 7
7. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	<input type="checkbox"/> Yes Coverage approved To determine quantity requirements, please complete Question 8	<input type="checkbox"/> No Coverage not approved
8. What is the dosing regimen?		

Note: For treatment of erectile dysfunction of organic origin unrelated to therapy for preservation or restoration of erectile function following prostatectomy, coverage is limited to a collective quantity (sildenafil, vardenafil and/or tadalafil combined) of 6 tablets per 30 days or 18 tablets per 90 days.

Please go to **Step 4** on Page 3.



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Section 3 – Male patients – Cialis and Viagra

1. Has the patient received a trial of Levitra (vardenafil) and had an inadequate response?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 2
2. Has the patient received a trial of Levitra (vardenafil), but was unable to tolerate it due to adverse effects?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 3
3. Is treatment with Levitra (vardenafil) contraindicated for this patient (e.g., due to hypersensitivity)?	<input type="checkbox"/> Yes Please sign and date	<input type="checkbox"/> No Proceed to Question 4
4. Is the requested medication being used for treatment of pulmonary arterial hypertension (PAH)?	<input type="checkbox"/> Yes Please sign and date Please complete Question 7	<input type="checkbox"/> No Proceed to Question 5
5. Is the requested medication being used for preservation/restoration of erectile function after prostatectomy?	<input type="checkbox"/> Yes Please sign and date Please complete Question 7	<input type="checkbox"/> No Proceed to Question 6
6. Is the requested medication being used for treatment of Raynaud's phenomenon?	<input type="checkbox"/> Yes Please sign and date Please complete Question 7	<input type="checkbox"/> No Coverage not approved
7. What is the dosing regimen?		

Please go to Step 4.**Step** I certify the above is correct and accurate to the best of my knowledge. Please sign and date:**4**_____
Prescriber signature_____
Date